Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.com
Have a Question? (855) 478-1528

AMVUTTRA® (vutrisiran) Referral

(- Required Fields)*

STAT REQUEST

(*REASON MUST BE PROVIDED BELOW)

New Referral **Referral Renewal** **Medication/Treatment Change**
Benefits Verification Only **Discontinuation Order**

PATIENT INFORMATION				
NAME*:		DOB*:	SEX: M F	
ADDRESS:		PHONE:		
WEIGHT: LBS	KG	HEIGHT:	EMAIL:	
ALLERGIES:				

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

AMVUTTRA Injection*:
*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ____________________________
(required & specific as possible)

25mg subcutaneously once every 3 months x1 year

Physician Signature* ____________________________ **Date*(Referral Valid for One Year)** ______________________

NPI # * ____________________

Infusion will be administered per VIVO policy and protocols

ICD-10 Description:

***STAT REASON:**
(STAT requests will be assessed per VIVO policy and protocols)

Last Infusion/Injection Date: ____________________

REQUIRED DOCUMENTATION CHECKLIST:

- Patient Demographics
- Insurance Card/Information
- Clinical/Progress Notes supporting DX
- Current Medication List and H&P
- Baseline PND Score
- Documentation of a gene TTR mutation
- Patient is taking Vitamin A
- Patient has not had a liver transplant

Additional comments/notes:

Locations:

--------Colorado-------

Lakewood

--------Florida---------

Jacksonville
Kissimmee
Port St. Lucie
Suncoast
Winter Park

------------Ohio------------

Beachwood
Middleburg Hts.
Painesville
Youngstown
Westlake
Fairlawn
Canton
Dayton

-------Oklahoma-------

Tulsa

---------Texas---------

Arlington
Cedar Hill
Dallas
Denton
Ft. Worth
Irving
Rockwall
Southlake
Flower Mound
Plano
Tyler

REVISION DATE- 10/2022